DOCUMENT RESUME

ED 440 351 CG 030 046

AUTHOR	Reid, Charrles; Kampfe, Charlene
TITLE	Multicultural Issues.
PUB DATE	2000-00-00
NOTE	20p.; In: Substance Abuse and Counseling; see CG 030 037.
PUB TYPE	Guides - Classroom - Teacher (052) -- Guides - Non-Classroom (055) -- Information Analyses (070)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Change; Counseling Techniques; Counselor Role; *Cultural Pluralism; Evaluation; History; Homosexuality; Lesbianism; Mythology; Older Adults; Prevention; Rehabilitation; *Substance Abuse
IDENTIFIERS	Addiction Counseling; *Multicultural Counseling

ABSTRACT

This chapter examines issues related to working with diverse populations with addictions. A brief history of multiculturalism and multicultural counseling is presented. Issues particular to the treatment of people with addictions are examined, as well as prevention and assessment issues. Substance abuse issues among people in the gay male and lesbian culture and the older population are examined. Suggestions for counselors working with these populations are provided. Multicultural models and concepts that could be applied to addiction populations are presented. Society has a role in addressing the issues of people with addictions because this population can have negative effects on society in general. With appropriate interventions, the negative effects of addiction can be mitigated and perhaps alleviated entirely. It is hoped that society will continue to explore alternative ways of addressing the issues that this population presents. Also included is a facilitator's manual which is a practical guide for teaching content through guided experiential projects. Eight objectives are listed, and seven student exercises are provided. (Contains 76 references.) (MKA)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 440 351

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Multicultural Issues

Charrles Reid & Charlene Kampfe

Introduction

This chapter will focus on multicultural issues in addictions. Myths and realities regarding substance abuse and minorities will be briefly discussed followed by a brief history of multicultural counseling. The majority of the chapter will present information regarding prevention of addictions, assessment strategies for identifying people with addictions, measuring instruments for evaluating counselor multicultural competencies, and culturally relevant treatment and theoretical approaches. The remainder of the chapter will describe issues related to addictions in the Gay and Lesbian Culture and in the older Population.

Myths and Realities

There appears to be a number of misconceptions concerning special populations and the use/abuse of illicit chemicals. It is widely believed that most of the cocaine users in America are from minority groups. However, according to the Substance Abuse and Mental Health Services Administration's National Household Survey on Drug Abuse (1997), people who are White are the largest group of cocaine users.Furthermore, they account for the majority of people who use heroin. The survey data indicate that African Americans comprise the lowest percentage of heavy drinkers when compared to Whites and Hispanics.

There is also a misconception that minorities make up the largest percentage of the prison population. According to Federal Bureau of Prisons (1999) statistics, Whites comprise approximately 60% of the federal prison population. Although the above-mentioned data may be new information to some counselors who work with diverse populations with addictions, many counselors may be aware that the number of people incarcerated for drug offenses is increasing. According to Federal Bureau of Prisons (1999), in 1970 only 16% of the federal prison population was reported as having drug offenses. By 1987, over 40% of people incarcerated had committed drug offenses; and by 1997, over 60% of federal inmates had drug offenses, with minorities having the largest percentage of increases.

Myths, stereotypes, and misconceptions have often influenced how society and the treatment community have addressed the issues of minorities who use or abuse substances. These have also influenced treatment models and practitioners. Dispelling myths and misconceptions about minorities would be a worthwhile endeavor because prevention, assessment, and treatment efforts could be grounded in knowledge rather than in erroneous beliefs. Furthermore, culturally sensitive treatment approaches may be developed to provide researchers and practitioners with a variety of options and models to address the needs of an increasingly diverse population.

Brief History of Multicultural Counseling

Before addressing other areas concerning multicultural issues in addiction studies, a brief overview of multiculturalism and multicultural counseling will be presented. Although these concepts are interrelated, they will be discussed separately.

Multiculturism

Banks and McGee Banks (1989) defined "multicultural" as the existence of many cultures within one society (p. 39). Banks (1994) described "multiculturalism" as a society in which all cultures are valid and valued, in which the values of others are respected and discussion is open, and in which the individuals from diverse ethnic, cultural, social-class and identity groups have equal opportunity to function in and be valued by society. For the purpose of this chapter, "diverse groups" include individuals from the gay and lesbian community, individuals who are older, and individuals with addictions.

People with addictions may be viewed as a culture because they perceive the world in a unique way.

CG 030046

BEST COPY AVAILABLE

This population has involvement in a specialized drug use subculture with its own lifestyles, behaviors, rituals and experiences. This subculture has language patterns unique to the group, and has societal norms to which group members adhere (e.g., do not give information to the police). Given this, people with addictions are also a part of the general society, and they continue to live and function in the social fabric. They are family members and community members. In order to have communities that function, the needs and experiences of all community members must be addressed, including people with addictions.

Multiculturalism has been an issue since the first people of different backgrounds and different cultures met centuries ago. In America, multiculturalism has been an issue from the time that Europeans first came to the continent (Jackson, 1995). According to Jackson, different cultural groups have continued to arrive in America. Their race and cultural similarity to the dominate group were two important factors that determined the ease with which and extent to which these groups would assimilate into the dominant, Western European-American, cultural group.

Multicultural Counseling

Aubrey (1977) indicated that the multicultural counseling movement began in earnest in the early 20th century when vocational counselors attempted to address the vocational needs of minorities, particularly Afrinesians (persons of African, Indian and Caucasian, or both, decent). Due to discrimination and prejudice, persons from minority groups were inappropriately counseled regarding their professional choices. Some vocational counselors excluded minorities from the process, while other vocational counselors matched the minority clients to employment that did not match their skills and abilities or to employers who would not hire them.

Laws were passed in the 1950s that made segregation illegal, and these laws influenced the way that counseling services were provided to minorities. Copeland (1983) has suggested that that the goal of counseling and vocational guidance for minorities in the 1950s was assimilation into the mainstream of American society with integration as the goal. Diverse cultural groups continued to maintain their heritages through churches, residential enclaves, social organizations, schools, and languages. As counselors continued to work with theories and techniques that were rooted in the ideas of the mainstream worldview, counseling "services" proved ineffective because counselors did not take the cultural backgrounds of their clients into consideration. During this period, practitioners and researchers began to identify the importance of culture and the impact of ethnocentric attitudes on the abilities of counselors to provide effective services (Davidson, Gibby, McNeil, Segal, & Silverman, 1950; Mussen, 1953; Siegman, 1958; Sperrazzo & Wilkins, 1959). According to Jackson (1995), multiculturalism for researchers and practitioners tended to focus on the administration of standardized tests, not the therapeutic relationship. "A major concern was the comparison of Blacks and Whites on various measures of intelligence" (p.8).

The 1960s saw continued growth and change in the movement toward multicultural counseling as American society began to address the concerns of minorities, with Black professional counselors at the front. Before the 1960s, minorities had little or no input in the decision making process of counseling institutions. Jackson (1995) stressed that the Civil Rights Act of 1964 had an impact on multicultural counseling in that this act lead to open discussions about the impact of race, discrimination, and prejudice and their influence on the counseling relationship. Aubrey (1977) observed that the increased racial and cultural diversity of counselors and counselors-in-training had the effect of making the counseling profession more responsive to the nation's diverse populations. Atkinson, Morton, and Sue (1979) noted that as society became more tolerant of cultural differences, the counseling profession mirrored that tolerance. Previously, counseling with minority clients had been done in segregated settings. When American schools and society were increasingly desegregated, cross-cultural counseling became more common and the inadequacies of cross-cultural counselor training became more obvious. Disenfranchised groups in America insisted that their unique counseling needs be met (Atkinson, Staso, & Hosford, 1978).

In the 1960s, the minority groups that received attention were African, Latino, Asian-Americans, and American Indians. In the 1970s, the concept of minority group expanded to include women, sexual orientation, and people with disabilities. (Jackson, 1995). The terms cross-cultural and multicultural counseling appeared in the literature as terms that described interactions between majority group counselors and minority group clients, minority group counselors and majority group clients, or counselors and clients who belonged to different groups. Davis (1978) stated that:

> The available counseling tools and techniques may be inappropriate for clients from a different culture and that multicultural counselors must be creative and flexible in their counseling style. A

> pluralistic perspective in counseling urges researchers, scholars, students, teachers and helpers to question the validity of current theories, techniques and strategies used in the profession. (p. 464)

Ornstein and Levine (1982) noted that this concept challenged majority group counselors to investigate their own cultural assumptions, how those assumptions affected interactions with clients, and the investigation of the value of assimilation and cultural diversity.

Multicultural counseling theory was refined in the 1980s and 1990s because people from diverse cultures were participants in the development of theory, and were active practitioners. Furthermore, diversity of thought was more acceptable. According to Jackson (1995), in past decades the counseling field was uniform because it was developed from one point of view, that of the Anglo-European. People of color were not present in counseling decision-making bodies or as practitioners. Because minorities were not considered a part of mainstream society, the needs and concerns of this segment of American society were often ignored. The techniques and strategies that were developed from the operational counseling theories reflected the implicit Eurocentric approach to client populations. Speight, Meyers, Cox and Highlen (1991) stated that numerous problems in the counseling arena existed because practitioners continued to address the issues of diverse populations with concepts and treatment models that were not culturally sensitive. Increased participation of professionals from diverse populations in the development of counseling theory and practice has influenced the counseling profession. The counseling profession can continue to incorporate culturally sensitive approaches and concepts in the 1990s and beyond, as exemplified by Sue and Sue (1999).

Multicultural counseling theory and practice have relevance when addressing the issues of people with addictions because this population shares much with other diverse populations. These people comprise a culture that transcends race, ethnicity, gender, age, socio-economic status, disability, and sexual orientation. On the other hand, excluding their drug use behaviors, they are also members of families, communities, and society. Multicultural treatment approaches that have been found to be useful with other diverse groups can be useful in addressing the issues of people with addictions. A discussion of multicultural treatment as it relates to addiction will be included later in this chapter.

Prevention

The major concepts of prevention have been covered in previous chapters. The purpose here is to identify a few prevention modalities that may have particular relevance to diverse populations. The concept of resiliency will be given some attention. It is important to remember that all diverse communities will not have the same prevention goals and there may be some disparity between individuals within communities.

Components of Prevention

A major component of prevention is education. The way education is provided to diverse populations may be a key to success. Three stages of prevention are usually recognized in the area of prevention of addictions (Inaba, Cohen, & Holstein, 1997; Ray & Ksir, 1999). These are primary, secondary, and tertiary. Primary prevention is aimed at young people who have not tried licit or illicit substances or have tried them only a few times. Secondary prevention focuses on people who are usually older and have had some experience with substances but do not need active treatment. Tertiary prevention is aimed at relapse prevention for those who have been in treatment or who have completed treatment.

Some authors have suggested that the development of spiritually may be a helpful prevention tool when working with diverse clients (Frame & Williams, 1996; Longshore, Grills, Annon, & Grady, 1998). Like the general population, diverse groups such as American Indians, African Americans, and Latinos have strong spiritual and religious convictions and values. These convictions and values can work as protective factors for those who have not yet begun using drugs or as a basis for relapse prevention for those who have used drugs. It should be noted that some people do not have religious or spiritual beliefs. For these people, the professional counselor and the person receiving counseling would have to clarify the person's value system and identify any of those values that may be helpful in prevention efforts.

Regardless of the site of prevention efforts (e.g., churches, programs, schools, prisons, or communities), it is important to maintain cultural congruence (Longshore et al., 1998). Counselors should use language that is congruent with the population addressed, maintain awareness of the effects of racism and discrimination on drug use behavior and emphasize the effects of each person's behavior on the wider community as well as the community's effect on each person's behavior. Relevant processes for prevention efforts include raising of

consciousness, examination of self and the examination of the environment in which prevention efforts are directed. These processes should be presented in a manner that is congruent with the population addressed.

Cultural minorities often reside in communities that provide social/cultural support and social assistance networks. The minorities may share beliefs, values, and experiences. Prevention efforts will have a better chance of success if people who live in the community are actively involved in all phases of the prevention effort because they add credibility and visibility to these efforts due to their social, professional, and familial standing in the community. Community leaders who seem to have social standing across groups include school teachers, sports personalities, newspaper editors, community health clinic personal, leaders in minority-oriented clubs and professional organizations, members of local health related volunteer organizations and businessmen's clubs members (Office of Substance Abuse Prevention, 1989).

Resiliency

The concept of resiliency may have some value when discussing prevention efforts, in general, and with diverse populations, in particular. This perspective emerged when researchers noted that some children were successful despite apparently overwhelming social and environmental odds (Jessor, 1993; Rutter, 1985). These researchers argued that instead of taking the negative approach of identifying "deficits" in children that lead to the "pathology" of drug use, focus should be placed on the strengths and supports that serve to counterbalance and mitigate the child's risk. Thus, resiliency is the ability to learn from adversity and to overcome risk in adverse situations.

Two categories of resiliency factors are the environment surrounding the child and personality traits within the individual child. By determining the environmental and personal sources of social resiliency, people who are concerned with prevention can better plan interactions that create and build the environmental and personal attributes that serve as a basis for healthy development. The extent to which youth are able to grow into healthy, responsible adults depends on the nurturing conditions provided in the major areas of the youth's life: the family, the school, and the community. The protective factors that support resiliency are similar in each environment. These factors include caring and support, high expectations, and the opportunity and encouragement to participate in and contribute to the meaningful activities of family, school, and community. Protective factors in the child can be reinforced within each of these environments. Children who have a sense of their own identity, who can act independently, and who are competent in social situations are better prepared to navigate the diverse streams of today's world (Reid, 1996; Jessor, 1993; Rutter, 1985). Reid (1996) compiled a list of personal qualities that have been consistently linked to resilient children:

- Social competence
- Good communication, problem solving, and critical thinking skills
- A sense of purpose
- A vision of the future
- A belief in one's ability to succeed, as opposed to an expectation of failure
- Independence and the ability to tap into one's own resources
- Feelings of positive self-esteem and of being able to control events in one's life (internal locus of control)
- Feelings of compassion and empathy for others
- An ability to delay gratification and control impulsive behavior
- An ability to make informed choices regarding the use of legal and illegal substances (p. 239)

According to Reid (1996), there may be as many resiliency factors as there are children. Each child is unique and may be reached in a unique way. The strategies discussed here are a starting point for endowing children with strengths that can assist them in avoiding substance abuse. The most effective approach to reduce children's vulnerability to substance abuse may be to help them develop the skills to meet their needs and to develop ways for them to contribute positively to the larger community.

Many of the above mentioned concepts of prevention can be helpful in reducing substance abuse in communities across America. Special attention can be given to at risk minority communities as they face unique and difficult challenges. Social institutions such as schools, mental health agencies, and social support agencies can provide much needed support in minority communities by providing role models, mentors, respite for parents, and examples of community members who have achieved degrees of success in society.

Assessment of the Client and the Professional

Multicultural assessment focuses on two areas. These areas are assessment of the culturally diverse client and assessment of the multicultural skills of the professional. Multicultural assessment in general will be addressed briefly, with the focus here being on multicultural assessment as it pertains to people with addictions.

Assessment for Addiction

In 1993, the Association for Assessment in Counseling, a division of the American Counseling Association, developed Standards and Guidelines for multicultural counseling. According to Prediger (1994), the Standards refer primarily to African Americans, Asian Americans, American Indians, and Latinos. The Standards are also useful in addressing the cultural issues of other groups, including people with addictions. The assessment-related tasks in the 34 Standards are: Selection of Assessment Instruments: Content Considerations; Selection of Assessment Instruments: Norming, Reliability, and Validity Considerations; Administration and Scoring of Assessment Instruments, and Use/Interpretation of Assessment Results. Prediger stated that if an instrument were inappropriate for multicultural populations, counseling based on interpretations of its results would probably be inappropriate.

There are a number of tools used to assess people with addictions, with the purpose of ascertaining if people are using or abusing various substances. Some, such as blood tests, urine tests, and genetic markers are beyond the scope of this paper. Ray and Ksir (1999) designated the American Psychiatric Association's Diagnostic and Statistical Manual, fourth edition, as the unofficial standard diagnostic tool used today. The National Council on Alcoholism Criteria for Diagnosis of Alcoholism is also commonly used (Inaba, et al., 1997). These diagnostic manuals address specific behaviors of substance users without placing a great deal of emphasis on cultural issues. This lack of cultural consideration seems to be standard for the paper and pencil instruments used to assess people with addictions. However, if used by professionals who are culturally aware and if the client answers with veracity and self awareness, the instruments can provide appropriate results for diverse populations (Harley, Greer, & Hackerman, 1997). Harley, et al., 1997 discussed three pencil and paper instruments: the CAGE, the Michigan Alcohol Screening Test (MAST), and the Substance Abuse Subtle Screening Instrument (SASSI). The CAGE is one of the oldest and shortest of the assessment techniques that is often used by medical doctors. It asks only four questions regarding cutting down, annoyance, guilt, and eye opening experiences. The MAST, a 25-item list of problems caused by alcoholism, is the most commonly used assessment method. Inaba et al., (1997) noted that the questions on the MAST focus on the detrimental life effects of alcohol on the user. There is also a short-form, 13-item MAST. Harley, et al. (1997) state that the SASSI was designed to assess substance abuse in a less obvious manner to ease test-taker resistance. The items on this instrument do not seem to be related to substance abuse. Another instrument that is increasingly being used is the Addiction Severity Index (ASI), developed by McLellan et al. (1992). It represents the most comprehensive assessment instrument for people with substance use issues. It can take over an hour to administer. The ASI assesses the person's level of functioning in seven life style areas: medical condition, employment status, legal and criminal status, drug and alcohol use, family history, family/social relationships, and psychiatric status. The ASI provides information on the respondent's age, gender, race/ethnicity, religion, and income. It appears to be the most culturally sensitive instrument and it has been used with a number of substance using populations.

Assessment for Cultural Sensitivity

A major concern in the treatment of culturally diverse people with addictions is the training of culturally sensitive professionals and assessing that training. Although it is beyond the scope of this paper to present the totality of information that has been generated in these two areas, some information of interest will be presented. The American Psychological Association cultural counseling competencies, a model for developing culturally sensitive professionals, and two instruments that assess the competency of professionals will be presented.

Since 1993, the American Psychological Association has required multicultural competencies for all counselors (Pope-Davis & Ottavi, 1994). The following is a list of those competencies:

1. Culturally skilled counselors have moved from being culturally unaware to being aware and sensitive to their own cultural issues.
2. Culturally skilled counselors are aware of their own values and biases and how they affect minority clients.
3. Culturally skilled counselors have a good understanding of the sociopolitical system's operation in the

United States with respect to its treatment of minorities.

4. Culturally skilled counselors are comfortable with differences that exist between the counselor and client in terms of race and beliefs.
5. Culturally skilled counselors are sensitive to circumstances that may dictate referral of the minority client to a member of his/her own race or culture.
6. Culturally skilled counselors must possess specific knowledge and information about the particular group they are working with.
7. Culturally skilled counselors must have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy.
8. Culturally skilled counselors must be able to generate a wide variety of verbal and nonverbal responses.
9. Culturally skilled counselors must be able to send and receive both verbal and nonverbal messages accurately and "appropriately" (APA Education and Training Committee of Division 17, 1980).

Sue et al. (1982) later added two more competencies to the list:

10. Culturally skilled counselors have an awareness of institutional barriers in mental health services.
11. Culturally skilled counselors make use of appropriate intervention skills (p. 651).

These competencies are similar to the framework suggested by Lopez et al. (1989). These authors use the concept of developmental stages for examining the expertise of counselors. Professionals proceed through stages or levels that build on what they have learned before, representing increasingly more intricate and versatile responses. This social cognitive framework provides a basis on which to determine how the professional processes information as his or her knowledge base and skill level increases. Professionals need to know when to apply specific norms for a particular group and when to apply universal norms. According to Lopez and associates, professionals may assume incorrectly that certain actions have the same significance for all people, when the significance of these actions is different for certain cultural group members. Or professionals may apply special norms to the actions of a specific group member when the special norms may not apply, as when a more universal norm is appropriate. Cultural sensitivity refers to the professional's ability to balance a consideration of universal norms, special group norms, and individual norms... Cultural sensitivity then involves balancing different norms and constantly testing alternative hypotheses" (p. 370).

Cultural sensitivity is an important concept for multicultural counseling. Another important concept is that of worldviews. Lopez et al. (1989) and other researchers (Sue & Sue, 1999; Trevino, 1996) have discussed the concept of worldviews with regard to multicultural theory and counseling. Regarding worldviews, Sue and Sue (1999) stated that:

> While there is a strong relationship between racial/cultural identify development and worldviews, the latter are more global and encompassing. Each and every one of us possesses a worldview that affects how we perceive and evaluate and how we determine appropriate actions based upon our appraisal; the nature of clinical reality is very much linked to worldviews. (p. 165)

The stages that reflect the professional's development of cultural sensitivity are:

(1) unawareness of cultural issues,
(2) heightened awareness of culture,
(3) burden of considering culture and
(4) toward cultural sensitivity (Lopez et al., 1989, p. 371).

In the first stage, unawareness of cultural issues, the therapist does not consider culture hypotheses. The result of this stage is that the professional does not comprehend the importance of the client's worldview and experiences to his functioning. In the second stage, heightened awareness of culture, the professional is aware that cultural factors are important in fully comprehending clients and their actions. This heightened awareness leaves the professional at a loss when working with culturally different clients. Therapeutically, the counselor frequently applies his perception of the client's cultural background and therefore, fails to understand how the client perceives his own background and its cultural importance. At times the professional at this stage is aware of the influence of the client's experiences and worldview on his functioning but, at other times, fails to grasp the importance of the client's worldview. The third stage involves the burden of considering culture. Here, the professional is hypervigilant in identifying cultural factors and at times is confused in determining the cultural significance of the client's actions. The result is that the professional perceives having to consider culture as detracting from the therapeutic process and this perception, in itself, detracts from the therapeutic process. In the final stage, toward cultural sensitivity, the professional entertains cultural hypotheses and tests these hypotheses from multiple sources before accepting cultural explanations. This hypothesis testing leads to increased chances

that the professional will accurately comprehend the role of culture in the client's functioning (Lopez et al., 1989). Professionals may go through similar stages when working with diverse populations with addiction issues.

According to Sue et al. (1982), culturally competent professionals are those who have moved from being culturally unaware to being sensitive to and aware of their own cultural issues. They consider and evaluate factors such as the impact of the American sociopolitical system on diverse populations. Culturally competent professionals have a knowledge base about particular cultural groups and they are able to formulate appropriate responses to the needs of their clients. Moreover, they are comfortable with the differences and similarities in beliefs between themselves and diverse groups, and are able to refer clients to members of their own culture when that is appropriate for the client to receive such services. Sue and Sue (1999) assert that the goals for culturally skilled professionals are to become aware of their own assumptions about human behavior, to seek an understanding of clients' assumptions about human behavior and to become active in developing appropriate interventions to assist clients.

Assessing the extent to which professionals have integrated awareness, skills and knowledge has been difficult. Two instruments in use that address the issue of cultural competency in professionals are the Multicultural Counseling Awareness Scale-Revised: Form B (MCAS) and the Multicultural Counseling Inventory (MCI). The MCAS is a 45-item self-assessment inventory developed by Ponterotto, Rieger, Barrett, & Sparks (1994). It uses a Likert-type scale to assess multicultural competencies, yielding subscale scores for knowledge/skills and awareness. The MCI is a 40-item inventory developed by Sodowsky, Taffe, Gutkin, and Wise (1994). This inventory uses a 4-point scale to measure self-reported multicultural counseling competency in four subscale areas: multicultural counseling skills, knowledge, awareness, and relationship. With these instruments and others, such as the Cross-Cultural Counseling Inventory developed by Hernandez and LaFromboise (cited in Pope-Davis & Dings, 1994), counselor education programs and professionals will be able to evaluate preparation programs and themselves. Improved skills on the part of professionals can result in better services for diverse populations with addictions.

Culturally Relevant Treatment and Theoretical Approaches

For a number of years, the disease model of addiction, exemplified by 12-step programs, has been widely used in the treatment of people with addictions (Ray & Ksir, 1999). Treatment models from the field of multicultural counseling may allow researchers and practitioners to better address the needs of their clients. Concepts from the field of multicultural counseling can provide a framework that allows professionals working with people to become more culturally sensitive to diverse populations, provide alternative treatment paradigms, and assist the professional in understanding the behaviors of culturally diverse clients.

Multicultural Oriented Approaches to Addiction Treatment

The most common treatment modality for addictions is the 12-step program with the goal of abstinence from all psychoactive substances (Ray & Ksir, 1999). This model continues to be used with culturally diverse populations and has been modified to be culturally sensitive. Alcoholics Anonymous groups now exist that address the needs of groups such as women, Indians, African Americans and Latinos who use substances .

A number of multicuitural counseling models have been developed over the years that may be useful when working with people with addictions; among them are the works of Trevino. This author helps professionals understand the history, lifestyles, experiences, and worldviews of culturally diverse populations (Ponterotto & Casas, 1990; Sue & Sue, 1999). In a broad view of multiculturalism, people with addictions can be viewed as having a unique culture (or culture within a culture) because they share aspects of worldviews, history, lifestyles, and experiences.

Trevino (1996) considers the importance of worldviews in counseling. According to Trevino, worldviews differ in levels of abstraction: broad core dimensions versus more specific dimensions. Aspects of the levels of abstraction may be either congruent or disparate between client and counselor. For Trevino, congruence of worldviews can strengthen the relationship between counselor and client, whereas disparate worldviews of client and counselor are better in encouraging client change. In this model of Multicultural Counseling and Therapy, the counselor could attempt to stay congruent with the client's worldview and at the same time encourage exploration of alternative perspectives that may be disparate. Thus, changes might take place in a specific domain of the client's worldview (i.e., substance abuse) while broader ways of perceiving the world would

initially remain the same. The client has the ability to change his broad core worldview dimensions if he chooses, but those changes are not demanded or imposed by the professional.

To facilitate the identification by the client of broad core worldview dimensions, a set of core values mutually held by counselor and client can be explored. Illustrations of Natural Law as postulated by Lewis (1947) could be helpful in that exploration. These Laws include The Law of General Beneficence; The Law of Special Beneficence; Duties to Parents, Elders and Ancestors; Duties to Children and Posterity; The Law of Justice; The Law of Good Faith and Veracity; The Law of Mercy; and The Law of Magnanimity. Adherence to the majority of these Laws by counselor and client may form the basis for a therapeutic relationship between people of diverse cultural groups, generally, and with people with issues of addiction, in particular. Sue & Sue (1999) states that worldviews can be conceptualized as a function of individual, group and universal experiences. In that case people with addictions would share many similar experiences with the counselor.

Addiction Theory Approaches for Working with Diverse Populations

Other culturally relevant approaches to working with people with addictions have been presented by De La Rosa, White, Segal, and Lopez (1999). They suggested that models and methods addressing drug behaviors for minority populations have not been effective because, for the most part, these have been modifications from models that were developed for White populations. These models have been restricted to psychological, sociological, and familial factors affecting drug behavior. This narrow perspective has resulted in models that have focused mainly on risk behaviors, and do not take into account the individual differences within minority populations. Furthermore, some theorists have failed to recognize the complexity of the mechanisms underlying drug use behaviors.

According to De La Rosa et al. (1999), a number of changes can be made to alleviate the above mentioned deficiencies in models that deal with minorities. These may also apply to models addressing addiction issues. First, theoretical models should be expanded to include cultural and community factors, because these factors are important to the experience of minority status in America. The effects of the extended family could be included in addiction treatment models, because the effects of extended families may be important determinants of drug behaviors within some groups. For some groups of people with addictions, community may be an important factor. In some urban areas, according to De La Rosa and associates, community factors such as poverty, poor schools, and inadequate housing may impact minority communities. These variables as well as questionable law enforcement have a greater effect on drug use behaviors in urban communities than in suburban communities. Another community factor that could be explored is the drug use behaviors of the community residents, whose behaviors could affect the behaviors of other residents in various ways. Some community residents are more accepting of drug use while other residents band together to eliminate drug dealers from the community.

When developing culturally relevant approaches to treating people with addiction issues, De La Rosa and associates stressed the need to include factors related to minority status such as the different experiences that they may have had with the majority population, the effects of discrimination, and the stress of acculturation.

The second postulate presented by De La Rosa et al. (1999) is that theoretical models need to be flexible so that they can be easily modified to reflect the between and within group differences in drug use populations. Racial classifications such as African American, Latino, and American Indian are much too broad. There are clear differences within the groups, which limit the generalizations that can be made about individuals in each of the groups. It is nearly impossible to develop theories or treatment models that accurately reflect individual differences within groups. It is, therefore, necessary to develop flexible models that can be modified to adjust to individual differences in people with addictions, regardless of their particular minority status or disability.

The third assertion of De La Rosa and associates (1999) is that treatment and theoretical models should be dynamic and multi-disciplinary. Current models are based on psychology and biology, but there is a growing awareness that there is a need to develop models with constructs from other disciplines when addressing the problems of people with addictions. Models of drug use behaviors can be developed that integrate constructs from the disciplines of biology, economics, organizational behavior, sociology and psychology for minority and addiction populations. Examples of integrated models for non-minority populations can be found in Huba, Wingard, and Bentler (1980) and Glantz (1992). Disciplines such as government, education, and rehabilitation have constructs that can add to our knowledge and understanding of drug use behaviors in minority and addiction populations. In developing models, it is necessary that drug use behaviors and the factors acting on them are viewed as dynamic, as are the social and economic conditions that may impede or facilitate such behaviors.

Finally, according to De La Rosa et al. (1999), theoretical and treatment models should be based on client assets, not solely on risk behavior orientations. Risk orientations focus on an individual's personality, family or environmental deficits, whereas protective orientations focus on factors that prevent or reduce addictions. Protective factors for minority populations with addictions may be different from majority populations because people in minority communities often have easy access to drugs and are living in poverty conditions.

Rehabilitation Approaches to Working with People with Addictions

The holistic discipline of rehabilitation includes approaches that may be useful in addressing the issues of diverse populations with addictions. Harley, Greer, and Hackerman (1997) capsulized some of the more frequently used rehabilitation approaches. Four models of helping are presented: medical, enlightenment, moral, and compensatory. The medical model is based on the assumption that the individual need not take responsibility for the problem or the solution. The enlightenment model (12-step treatment model) assumes that the client is responsible for the problem, but not for the solution. The moral model puts the responsibility, as well as the solution to the problem, on the client. The compensatory model suggests that the client is not responsible for the problem but is responsible for the solution, thus the professional and the client work as a team, with the client being responsible for changes in his or her life. The goal here is to empower the client. This model is person-centered and promotes adjustment and the internalization of healthy coping skills. The compensatory model is seen as the most therapeutic in working with people in general and particularly with diverse populations (i.e., people with addictions) (Harley et al., 1997). By defining culture broadly, rehabilitationists can examine the way they deliver services and the responses of clients from a nonjudgmental and multidimensional perspective, incorporating cultural diversity as well as cultural compatibility when addressing the needs of the various populations they serve.

Institutional Change

When examining culturally relevant approaches for people with addictions, it may be helpful to briefly explore the goals of treatment for the individual, the role of the established organizational institutions that maintain the status quo and the goals of society regarding people with addictions. According to Ray and Ksir (1999), the predominant view is that addiction is a disease with the only acceptable treatment goal being total abstinence from all psychoactive substances. Other theorists (e.g., Peele, 1985) view addiction as one point in a continuum of many substance use behaviors. People can move back and forth on the continuum depending on a variety of factors. For some theorists, controlled drug use can be a beneficial treatment outcome.

Perhaps it would be useful to have more than one treatment goal, so that goals can be tailored to specific populations and individuals. In a society that has diverse populations and many causal factors for drug use, there could be a number of acceptable treatment goals as opposed to the current view that abstinence is the only viable treatment option. Atkinson, Brown, and Casas (1996) have put forth ideas regarding multicultural organizational development that may be generalized to the area of multicultural counseling with people with addictions. First, the reasons for having multiple treatment goals should be clearly articulated. The barriers to multiple acceptable treatment goals should be understood and ways to overcome the barriers developed. Second, a sincere commitment to address multicultural issues when working with people with addictions must come from the top. Program administrators, journal editors, addiction educators, and established practitioners must be convinced that a "one size fits all" model does not serve the client, the field of addictions treatment, or society. Third, change must be directed by the institutions that influence addiction treatment: its programs, policies, practices and structures. For example, professionals may be versed in the concepts of multiculturalism and have the ability to apply those concepts to diverse populations with addictions. Institutions that are accepting of change will be more amenable to accepting a range of treatment goals for clients and more open to professionals who advocate change. Finally, the field of addiction treatment must continue to be proactive, developing nontraditional strategies for working with nontraditional populations, and continue to change as the population changes.

Des Jarlais (1995) has presented some basic components of a harm-reduction framework that may be useful in a societal debate regarding drug policy in America. He has suggested that drug use can be viewed as a public health issue rather than a criminal justice issue (see Erickson, Riley, Cheung & O'Hare, 1997, for a review). From the premise that non-medical drug use will probably continue, it is the job of government, the

treatment community and society to reduce its harmful effects as much as possible while educating the populace.

Perhaps the goal of treatment, for all people with addictions, may not be abstinence but the reduction of harmful effects that drug use has on society. Perhaps the goal is to reduce crime, reduce domestic violence, return people to productive employment, increase the person's level of functioning and educate future generations.

Addiction Issues in the Gay and Lesbian Culture

The Issues

The emergence of a gay and lesbian culture presents unique issues with regard to substance use/abuse. Pressures faced by this population such as stigma, discrimination, social rejection by the heterosexual community, and identity and life style development issues challenge the counseling professional to clarify his or her own values regarding this population and to work within the gay and lesbian worldview (Teague, 1992). Stress, due to gender identification issues and social rejection issues, is a factor in gay and lesbian substance use/abuse (Coleman, 1982; Kus, 1988).

For some youth, substance use can be a way of coping with the turmoil associated with sexual development and orientation (Gibson, 1989). This process may be a particularly difficult adjustment for gay men and lesbians because they may go through identity development stages similar to racial and ethnic groups (see Atkinson, Morton & Sue, 1979). A theoretical model proposed by Cass (1979) suggested that people in the gay or lesbian culture progressed through six stages of identity to reach identity congruence. Although not all individuals experienced all stages and time frames, the theoretical model provides a frame work for understanding identify development in gay men and lesbians. The issue of identity congruence is dramatic for gay men and lesbian women who are also otherwise culturally different. Garnets and Kimmel (1991) suggested that, frequently, the dilemma for racial or ethnic minority lesbians and gay men becomes one of managing conflicting allegiances among different communities. They must participate in divergent social worlds, balancing demands and crossing boundaries of the different groups, including the gay male and lesbian community, one's ethnic culture, the majority culture, and for women, the women's or feminist community. Individuals with double or triple minority status may experience discrimination and prejudice as outsiders in each community. Although the goal may be to identify with, or be a part of, both the ethnic or racial and lesbian and gay male communities, typically the result is greater comfort in the gay male and lesbian community but a stronger identity with the ethnic or racial group. (p. 156) This cultural group, like other groups, has a desire to meet with and share experiences with others, receive positive reinforcement from people with similar values and exhibit their culture in areas where that culture is socially accepted. Bars, nightclubs, and "raves" have been places where gay males and lesbians have met to express and solidify their identity (Stevens-Smith & Smith, 1998).

These venues continue to be, at present, indispensable for this community to maintain and increase solidarity, comradeship, and social interaction (O'Donnell, Leoffler, Pollack, & Saunders, 1980). These venues, while serving a social purpose, can also provide opportunities for the increased likelihood of drug and alcohol use and possibly abuse and possible HIV infection, if the person does not maintain a balanced life style with positive self-regard (Blume, 1985; McAllan & Ditillo, 1994). Counselors and other helping professionals can be influential in assisting gay males and lesbians maintain a balanced lifestyle and develop positive self- regard.

Suggestions for Counselors

Counselors and helping professionals should be nonjudgmental, as much as possible, during the counseling process; but as McAllan and Ditillo (1994) suggest, that does not mean that professionals cannot assist clients in self advocacy, provide information or educate themselves about issues of concern to their clients. These suggestions may be helpful in assisting the gay male or lesbian client in identity development, reducing drug and alcohol abuse and maintaining a balanced lifestyle with positive self-regard.

McAllan and Ditillo (1994) provide some specific suggestions that can help the professional become effective when working with gay males and lesbian women, regardless of the presenting problem. They suggest that counselors:

(1) Get to know your clients as individuals, not as stereotypes;
(2) Do not assume heterosexuality or homosexuality about your clients;
(3) Do not assume that marriage and children exempt a person from being gay or lesbian;
(4) Do not assume disability causes gayness or that poor parenting or overprotection result in dependency and gayness;

(5) Do not try to convince your client that she/he is not lesbian or gay and suggest that her/his sexual orientation is caused by limited social contact; and
(6) Do not assume that sexual orientation is the basis of all the psychological and social problems a client identifies. (p. 29)

The above suggestions may be useful when working with clients who are gay males and lesbian women, who have substance abuse issues because the suggestions: can provide a basis to begin the therapeutic relationship, indicate that the professional is willing to work with the whole person and that the professional is non-judgmental during the therapeutic process, and indicate that the individual is important. The importance of treating gay males and lesbians as individuals was noted by Garnets and Kimmel (1991), who indicated that although gay males and lesbian women have some similar sexual orientation issues, the groups are treated differently by family, friends and society. Also, gender identification can be as influential as sexual orientation. For example, gay males may identify with many of the masculine roles and values that heterosexual males value, while lesbians may face the same types of discrimination faced by heterosexual women.

The counselor working with gay males and lesbians with substance issues, as with any population, should have and understanding and appreciation of her/ his own worldview. One must be cognizant of the perceptions, stereotypes, experiences, and beliefs that she/he brings to the counseling process and have an awareness of how these variables affect the therapeutic process (Garnets & Kimmel, 1991; McAllan & Ditillo, 1994).

Substance Misuse Issues for People Who Are Older

The Issues

Although people who are older do not constitute a specific cultural group, they do share specific issues regarding substance use. The major concerns for this group are the misuses of over-the-counter and prescription drugs (George, 1990; Gurwitz & Avorn, 1991) and the excessive use of alcohol (George; Hazelden Corporation, 1996; Stevens-Smith & Smith, 1998). These problems are exacerbated by physical risk factors associated with an aging body. Older peoples' bodies are less able to metabolize drugs and alcohol than younger peoples' bodies, therefore substance use can have more severe effects on older people (Burger, Fraser, Hunt, & Frank, 1996; Stevens-Smith & Smith; U. S. Office of Technology Assessment, 1985). Misuse of medications and alcohol use are often undetected because the typical signs of their use might also be typical symptoms of physical conditions experienced by older people. Examples of warning signs of substance misuse or addiction are tremors, unsteadiness, constipation, depression, malnutrition, fatigue, drowsiness, memory loss, falling, and anxiety. All of these signs could be misread by the professional as symptoms of a medical problem that is unrelated to drug or alcohol use (Hazelden Corporation, 1996; Stevens-Smith & Smith, 1998).

The misuse of drugs can take many forms. It can involve excessive use, inconsistent use, under-use (Gurwitz & Avorn, 1991), medication sharing, and ingestion of multiple drugs without the proper direction of a physician (Stevens-Smith & Smith, 1998). Furthermore, it can be the result of over-or under-medication by individuals who are administering the drugs (Burger et al., 1996; Butler & Lewis, 1982) or of multiple medications that have been prescribed by physicians (Stevens-Smith & Smith). Because older people typically experience a variety of health problems, it is not uncommon for individuals to receive at least 13 prescriptions per year (Stall, 1996). This polypharmaceutical practice can result in adverse effects or in drug potency alterations (Bressler & Conrad, 1983; Burger et al.). In addition to these prescribed medications, older people may be taking a variety of over-the-counter drugs (George, 1990) that may interact negatively among themselves and with other prescription drugs that are being taken (Stevens-Smith & Smith). Individually, and in combination, these types of misuse may result in adverse consequences (Burger et al., 1996; Gurwitz & Avorn, 1991).

Excessive alcohol use is a potential problem for older people (George, 1990). For example, one study reported that 70% of hospitalized older people have alcohol-related problems and that 20% have been diagnosed with alcoholism (Hazelden Corporation, 1996). Older people are at risk of alcoholism for a variety of reasons. Often they have experienced multiple losses not only of their body systems but also of their friends, families, occupations, income, residence, and autonomy. These losses may leave them with reduced mobility, grief issues, declining social support, time on their hands, and a sense of disempowerment (Kampfe, 1993/1994, 1998; Meyers, 1990; Stevens-Smith & Smith, 1998; Waters & Goodman, 1990). If they turn to alcohol, it may have more severe effects on their bodies and functioning than it would have on younger people's bodies. For example, a lower level of alcohol can cause significant impairment in motor skills and cognition for older people. It can increase the output and rate of the heart, and it can result in alcohol-induced hypoglycemia (Levy,

Duga, Girgis, & Gordon, 1973 as cited in Stevens-Smith & Smith).

Suggestions for Counselors

It will be important for counselors to identify the risk factors of substance abuse for each of their clients. As mentioned earlier, older individuals experience multiple losses at a much higher degree than do younger people. As a preventative measure, counselors can assist individuals in dealing with these losses and in finding new, meaningful ways to spend their lives. Helping people work through their losses can involve a variety of skills and attitudes. To begin with, counselors need to respect their clients' unique understanding of the life events that they have experienced. That is, the counselor will want to understand each loss from their clients' worldviews, and help them express thoughts and feelings about the loss. This understanding can be accomplished by using active listening skills that involve empathetic paraphrasing, reflecting, questioning, and summarizing (Kampfe, 1993/1994, 1995; Myers & Schweibert, 1996; Schlossberg, 1984; Waters & Goodman, 1990). The counselor can then help these individuals identify ways that their lives are and can be meaningful, focus on their functional capacities, develop or affirm a sense of control over their circumstances (Brandstadter & Baltes-Gotz, 1990; Crewe, 1992; DeLoach, 1992; Folkman, 1984; Kampfe, 1998; Krause, 1986; Myers, 1990; Waters & Goodman), and establish or maintain social support from those around them (Hansson & Carpenter, 1994).

Counselors can work with the environment to encourage greater opportunities for social interaction (DeLoach, 1992; Stevens-Smith & Smith, 1998). This might be done by providing training to health care workers regarding the importance of social support; by starting peer support groups; by identifying social support agencies, organizations, or programs that already exist in the community; and by involving family members in the client's life. Discussions with other people about the client should not be undertaken without the client's permission (American Counseling Association Code of Ethics, 1997), and it is best to include the client in these interactions.

Counselors can also be aware of the signs of substance misuse or excessive alcohol use, and be vigilant when clients have been diagnosed with medical conditions that might share common symptoms of the abuse. Misdiagnosis can be deleterious to an individual's health, and can supersede any appropriate treatment for substance use.

Counselors need to be aware of the potential misuse of substances, and to ask their client about his or her over-the-counter and prescription drugs (Stevens-Smith & Smith, 1998). It is not always enough to ask the client to list the medications being taken, because there are often so many that it is difficult to remember all of them. One technique that is particularly helpful is to ask about each of the client's conditions and then to ask about the drug that is being taken for that condition. Another technique is to walk through the house and ask the client to show you the medications in each room. For example, one might ask to see the medications in the kitchen drawer or windowsill, the drugs beside a favorite chair, those beside the bed, and those in the bathroom. If counselors can not visit the home, they can simply ask the client about the drugs for each condition or in each room. These prompts can assist the client in generating a complete list of the medications being taking. The client can then confer with his or her pharmacist or physician regarding their interactive effects. Counselors can also provide information about the potential deleterious effects of overuse, under use and inconsistent use of medications.

Summary

This chapter examined issues related to working with diverse populations with addictions. Much of the information may be applicable to other populations. Issues particular to the treatment of people with addictions were examined, as well as prevention and assessment issues. Substance abuse issues among people in the gay male and lesbian culture and the older populations were examined. Multicultural models and concepts that could be applied to addiction populations were presented.

Society has a role in addressing the issues of people with addictions because this population can have negative effects on society in general. With appropriate interventions, the negative effects of addiction can be mitigated and perhaps alleviated entirely. It is hoped that society will continue to explore alternative ways of addressing the issues that this population presents.

References

American Counseling Association. (1997). *Code of ethics and standards of practice.* Alexandria, VA: American Counseling Association.

Atkinson, D. R., Brown, M. T., & Casas, J. M. (1996) Achieving ethnic parity in counseling psychology. *The Counseling Psychologist, 24* (2), 230-258.

Atkinson, D. R., Morton, G., & Sue, D. W. (1979). *Counseling American minorities: A cross-cultural perspective.* Dubuque, IA: William C. Brown.

Atkinson, D. R. Staso, D., & Hosford, R. (1978). Selecting counselor trainees with multi-cultural strengths: A solution to the Bakke decision crisis. *Personnel and Guidance Journal, 56* (1), 546-549.

Aubrey, R. F. (1977). Historical development of guidance and counseling and implications for the future. *Personnel and Guidance Journal, 55*(1), 288-295.

Banks, J. A. (1994). *Multicultural education: Theory and Practice* (3rd ed.). Needham Heights, MA: Allyn & Bacon.

Banks, J. A., & McGee Banks S. A. (1989). *Multicultural education: Issues and perspectives.* Needham Heights, MA: Allyn & Bacon.

Blume, E. S. (1985). Substance abuse (of being queer, magic pills, and social lubricants). In H. Hidalgo, T. L. Peterson, & N. J. Woodman (Eds.), *Lesbian and gay issues: A resource manual for social workers* (pp. 79-87). Silver Spring, MD: National Association of Social Workers.

Brandstadter, J., & Baltes-Gotz, B. (1990). Personal control over development and quality of life perspectives in adulthood. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences.* Cambridge, England: Cambridge University Press.

Bressler, R., & Conrad, K. A. (1983). Clinical pharmacology. In F. U. Steinberg (Ed.), *Care of the geriatric patient* (pp. 256-274). St. Louis, MO: C. V. Mosby.

Burger, S. G., Fraser, V., Hunt, S., & Frank, B. (1996). *Nursing homes: Getting good care there.* San Luis Obispo, CA: Impact.

Butler, R. N. & Lewis, M. I. (1982). *Aging and mental health* (3rd ed.). St Louis, C. V. Mosby.

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4,* 219-235.

Coleman, E. (1982). Chemical dependency and intimacy dysfunction: Inextricably bound. *Journal of Chemical Dependency Treatment, 1,* 13-26.

Copeland, E. J. (1983). Cross-cultural counseling and psychotherapy: A historical perspective. Implications for research and training. *Journal of Counseling and Development, 62,* 10-15.

Crewe, N. M. (1992). Functional assessment and the Americans with Disabilities Act. In J. K. O'Brien (Ed.), *National short-term training program: Americans with Disabilities Act* (4th ed., pp. 96-115). Carbondale: Rehabilitation Continuing Education Program, Southern Illinois University.

Davidson, K. S., Gibby, R. G., McNeil, E. B., Segal, S. J., & Silverman, H. (1950). A Preliminary study of Negro and White differences on Form 1 of the Wechsler-Bellevue Scale. *Journal of Consulting Psychology, 13*(1), 298-300.

Davis, R. V. (1978). A paradigm and model for cross-cultural study of counseling. *Personnel and Guidance Journal, 56* (1), 463-466.

De La Rosa, M.R.,White, M.S., Segal, B., & Lopez, R., (1999) Conducting drug abuse research with minority populations: conclusions and recommendations. *Drugs & Society, 14,* 269-283.

DeLoach, C. (1992). The independent living movement. In J.K. O'Brien (Ed.), *National short-term training program: Americans with Disabilities Act* (4th ed., pp.68-95). Carbondale: Rehabilitation Continuing Education Program, Southern Illinois University.

Des Jarlais, D. C. (1995). Harm reduction: A framework for incorporating science into drug policy. *American Journal of Public Health, 85,* (1), 10-12.

Erickson, P. G., Riley, D. M., Cheung, Y. W., & O'Hare, P. A., (1997). *Harm Reduction: A new direction for drug policies and programs.* Toronto: University of Toronto Press.

Federal Bureau of Prisons Quick Facts: 1999. Available Internet (http://.bop.gov/facto598.html).

Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. *Journal of Personality and Social Psychology, 46,* 839-852.

Frame, M. W., & Williams, C. B. (1996). Counseling African Americans: Integrating spirituality in therapy. *Counseling and Values, 41,* 16-25.

Garnets, L. & Kimmel, D. (1991) Lesbian and gay male dimensions in the psychological study of human diversity. In J. D. Goodchilds (Ed.), *Psychological perspectives on human diversity in America.* Washington, DC: American Psychological Association.

George, R. L. (1990). *Counseling the chemically dependent: Theory and practice.* Upper Saddle River, NJ: Prentice Hall.

Glantz, M. (1992). A developmental psychopathological model of drug abuse vulnerability. In M. D. Glantz & R. Pickens (Eds.), *Vulnerability to drug abuse.* Washington, DC: American Psychological Association.

Gibson, P. (1989). Gay men and lesbian youth suicide. In M. Feinleib (Ed.), *Report of the secretary's taskforce on youth suicide* (pp. 3-11). Washington, DC: US Department of Health and Human Services.

Gurwitz, J. H., & Avorn, J. (1991). The ambiguous relation between aging and adverse drug reactions. *Annals of Internal Medicine, 114,* 952-965.

Hansson, R. O., & Carpenter, B. N. (1994). *Relationships in old age: Coping with the challenge of transition.* New York: Guilford.

Harley, D. A., Greer, B. G., & Hackerman, A. E. (1997). Substance abuse and rehabilitation. *Rehabilitation Education, 11* (4), 353-372.

Hazelden Corporation (1996). Alcoholism and drug abuse: A growing problems among the elderly. On the World Wide Web, 1-2.

Huba, G. J., Wingard, J. A., & Bentler, P. M. (1980). Framework for interactive theory of drug abuse. In D. J. Letterie, M. Sayers, & H. W. Pearson (Eds.), *Theories on drug abuse: Selected contemporary perspective* (NIDA Research Monograph 130, Pub. No. (ADM) 84-967, pp. 95-101). Rockville, MD: U.S. Government Printing Office.

Inaba, D. S., Cohen, W. E., & Holstein, M. E. (1997). *Uppers, downers, all arounders: Physical and mental effects of psychoactive drugs* (3rd ed.). Ashland, OR: CNS.

Jackson, M. L. (1995). Multicultural counseling: Historical perspectives. In J. G. Ponterotto & J. M. Casas (Eds.), *Handbook of multicultural counseling* (pp. 3-16). Thousand Oaks, CA: Sage.

Jessor, R. (1993). Successful adolescent development among youth in high risk settings. *American Psychologist, 48* (2), 117-26.

Kampfe, C. M. (1993/1994). Vocational rehabilitation and the older population. *The Southwest Journal on Aging, 9* (2), 65-69.

Kampfe, C. M. (1995). Empowerment in residential relocation and long-term care settings. In K. V. Chandras. *Handbook on counseling adolescents, adults and older persons.* Alexandria, VA: ACES Adult Development, Aging and Counseling Network, Association for Counselor Education and Supervision.

Kampfe, C. M. (1998). Residential relocation of people who are older: Relationship among life satisfaction, perceptions, coping strategies, and other variables. *Journal of Adult Development and Aging: Theory and Research* (On-line). 1 (1). Available: http://www.uncg.edu/ced/jada.

Krause, N. (1986). Stress and coping: Reconceptualizing the role of locus of control beliefs. *Journal of Gerontology, 41,* 617-622.

Kus, R. (1988). Alcoholism and non-acceptance of gay self: The critical link. *Journal of Homosexuality, 15,* 25-41.

Lewis, C. S. (1947). *The abolition of man: How education develops man's sense of morality.* New York: Macmillan.

Longshore, D., Grills, C., Annon, K., & Grady, R. (1998). Promoting recovery from drug abuse: An Africentric intervention. *Journal of Black Studies 28,* (3), 319-332.

Lopez, S. R., Grover, K. P., Holland, D., Johnson, M. J., Kain, C. D., Kanel, K., Mellins, C. A., & Rhyne, M. C., (1989). Development of Culturally Sensitive Psychotherapists. *Professional Psychology: Research and Practice, 20* (6), 369-376.

McAllan, L. C., & Ditillo, D. (1994). Addressing the needs of lesbian and gay clients with disabilities. *Journal of Applied Rehabilitation Counseling, 25* (1), 26-34.

McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H., & Argeriou, M. (1992). The fifth edition of the Addiction Severity Index. *The Journal of Substance Abuse Treatment, 9,* 199-213.

Mussen, P. H. (1953). Differences between the TAT responses of Negro and White boys. *Journal of Consulting Psychology, 17* (5), 373-376.

Myers, J. E. (1990). *Empowerment for later life.* Ann Arbor, MI: ERIC Counseling and Personnel Services Clearinghouse.

Myers, J. E., & Schweibert, V. L. (1996). *Competencies for Gerontological Counseling.* Alexandria, VA: American Counseling Association.

O'Donnell, M., Leoffler, V., Pollock, K., & Saunders, Z. (1980). *Lesbian health matters.* Santa Cruz, CA: Women's Health Center.

Office of Substance Abuse Prevention. (1989). *Prevention plus II: Tools for creating and sustaining drug-free communities.* (DHHS Publication No. ADM 89-1649). Rockville, MD: National Clearinghouse for Alcohol and Drug Information.

Ornstein, A. C., & Levine, D. U. (1982). Multicultural education: Trends and issues. *Childhood Education, 58,* 241-245.

Peele, S. (1985). *The meaning of addiction: Compulsive experience and its interpretation.* Lexington, MA: Lexington Books.

Ponterotto, J. G., & Casas, J. M. (1990). *Handbook of racial/ethnic minority counseling research.* Springfield, IL: Charles C Thomas.

Ponterotto, J. G., Rieger, B. P., Barrett, A., & Sparks, R. (1994). Assessing multicultural counseling competence: A review of instrumentation. *Journal of Counseling & Development, 72,* 316-322.

Pope-Davis, D. B., & Dings, J. G., (1994). An empirical comparison of two self-report multicultural counseling competency inventories. *Measurement and Evaluation In Counseling and Development, 27,* 93-101.

Pope-Davis, D. B., & Ottavi, T. M. (1994). Examining the association between self-reported multicultural counseling competencies and demographic variables among counselors. *Journal of Counseling & Development, 72,* 293-297.

Prediger, D. J. (1994). Multicultural assessment standards: A compilation for counselors. *Measurement and Evaluation in Counseling and Development, 27,* 68-73.

Ray, O., & Ksir C. (1999). *Drugs, society, and human behavior* (8th ed.). Boston, MA: McGraw-Hill.

Reid, C. R. (1996). Promoting resiliency: Classroom strategies that foster students' strengths. In S. F. Moore & A. Sales (Eds.), *Preparing tomorrow's teachers in substance abuse prevention: A curriculum for teacher education* (Rev. ed.) (pp. 238-242). Tucson, AZ: University of Arizona.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147,* 598-611.

Schlossberg, N. K. (1984). *Counseling adults in transition.* New York: Springer.

Siegman, A. W. (1958). The effects of cultural factors on the relationship between personality, intelligence, and ethnocentric attitudes. *Journal of Consulting Psychology, 22* (5), 375-377.

Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Multicultural Counseling Inventory (MCI): A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41,* 137-148.

Multicultural Issues

Charrles Reid & Charlene Kampf

Rationale

Awareness of multicultural issues has become a dynamic part of the therapeutic process in all counseling disciplines and in American society in general. Professionals who are aware of their own cultural issues and the cultural issues of people with addictions can be more effective in the therapeutic process. Information briefly tracing the history of multicultural counseling with narrow and broad definitions provides a basis for understanding the role of cultural sensitivity when working with diverse populations with addictions. Prevention approaches can be helpful in educating individuals and communities about the dangers of addiction. Assessment of the client with regard to identification of substance abuse will be assistive, however professionals must be aware of any cultural biases of these tests. Counselor education and service programs need appropriate instruments to assess the success of their multicultural instruction and the knowledge base of the professionals associated with these programs. It is also important to have an awareness of how diverse populations with addictions perceive the world. Knowledge about cultural contributions to drug use behavior will help professionals identify therapeutic strategies and interventions that will assist the professional and the client in achieving the agreed upon therapeutic goals. Various multicultural counseling concepts and theories have applications to diverse populations with addictions and the use of a variety of outcome goals can increase treatment success.

Overview

This chapter addresses the myths associated with special populations and their use of chemicals, the history of multiculturalism and multicultural counseling, assessment strategies, various culturally relevant concepts and approaches, and treatment strategies that pertain to working with people with addictions.

Objectives

1. To become sensitive to and aware of society's and one's own myths about special populations and the use or abuse of drugs.
2. To develop awareness of the role of culture for the professional and the person with addictions.
3. To review the history of multiculturalism.
4. To examine the development of multicultural counseling and its relevance to people with addictions.
5. To become aware of various theories and strategies that can be effective in prevention when working with people with addictions.
6. To experience the assessment process for substance use, and to evaluate various tests for cultural biases.
7. To evaluate one's own cultural competencies using assessment instruments.
8. To be aware of culturally relevant treatment approaches with people with additions.

Activities

These activities will personalize learning related to multiculturalism, prevention strategies, assessment concepts and treatment approaches as they relate to people with addictions.

Exercise I for Objectives 1 & 2: Myths, Realities, and Role of Culture

1. Ask two students to stand in front of the class about 15 to 20 feet apart facing each other. After they have faced each other, tell each of them that they will represent a person from a particular cultural group. (e.g., one could be White and another could be Native American or one could be young and another could be old). Then identify one of these individuals as a counselor and the other as a client.

2. Invite members of the class to identify biases/myths surrounding the culture of the individual who represents the client (e.g., Native American client). Focus can be on myths associated with drug and alcohol use in this culture. As each class member identifies a myth about the client's culture, ask the class member to stand between the two individuals facing the counselor. Continue asking for myths and biases about the client's culture until you have a row of people standing in a line that obscures the view that the counselor has of the client.
3. Discuss the meaning of this experience. If it is not obvious to the class, ask them to consider the following:
   a. like this concrete/objective line, each of the biases or myths might obscure the counselor's perception of the client's worldview,
   b. even one of these myths/biases obscures the counselor's ability to see the client, therefore a combination of them might result in dramatic effects,
   c. invite them to consider how they, themselves actually perceive people from the particular culture discussed in this exercise.
4. Ask the class members to sit down, the two individuals to remain standing, and to maintain the roles they represented in the first exercise. In a similar manner as before, ask the class members to identify the cultural myths or biases associated with the cultural group represented by the counselor (i.e, White counselor). Again ask them to stand between the client and counselor, but this time facing the client. Students can now see how myths and biases can act as barriers between the counselor and client in yet another way. Follow this with discussions of the meaning of this aspect of the exercise.
5. Ask the class members to sit down again, but ask the two individuals to remain standing one more time. Ask them to reverse the counselor/client roles they represent. For example, if the Native American was the client during the first part of this exercise, he or she can be the counselor during this exercise. In the same manner as before, ask the class to identify myths and biases associated with the culture represented by the new counselor; forming a barrier between counselor and client. Discuss the meaning of this experience. In this instance, students can become aware that myths and biases can work both ways (that is all cultures may have some biases about all others), and that we all must work to maintain a clear view of the other person's unique worldview.

Exercise II for Objective 2 & 3: Culture of Professional and Multiculturalism

1. Request that students express their ideas about the definition of multiculturalism during a discussion based on questions such as these:
   a. What changes have you seen in your family, school, community and society since the advent of multiculturalism?
   b. What is your culture and what are the values and beliefs of that culture?
   c. How do you feel about other cultures influencing your culture?
2. Divide students into groups of three to five. Ask them to recall and discuss their first encounters with a person with an addiction. What were their personal reactions and the reasons for those reactions? If there were negative attitudes about people with addictions, where did the negative attitudes originate? Ask the groups to share in class discussion.

Exercise III for Objective 4: Multicultural Counseling

1. Divide the class into small groups and give each group a flip-chart. Ask the groups to list important multicultural counseling strategies that they have studied. Following each of these strategies, ask them to indicate how these might be applied to people with addictions. At the end of the class, ask students to report their results back to the entire group. Help them to see common themes and potential ways to expand their ideas.

Exercise IV for Objective 5: Prevention

1. Divide the students into small groups. Have them discuss and evaluate the risk that substance abuse education programs can have on substance abuse. Ask students about the effects on them of drug education they received at school, at home and in this course. Facilitate a classroom discussion regarding prevention education and prevention programs that would be useful with diverse populations

of substance abusers and in diverse population communities.

Exercise V for Objective 6: Assessment for Substance Abuse

1. Invite students to take each of the following assessment instruments: the screening tool that focuses on cutting down, annoyance, guilt, and needing an eye-opener (CAGE); the Michigan Alcohol Screen Test (MAST); the Substance Abuse Subtle Screen Instrument (SASSI); and the Additions Severity Index (ASI).
2. As a follow-up, ask the class to compare the results of the four tests, focusing on the following questions:
   a. Did any of the instruments have obvious cultural biases?
   b. Were the results similar/different for each test?
   c. What did each test focus on?
3. Invite students to take the same tests again, but as if they were a person from a particular culture and who has a substance abuse issue.
4. Ask the class to discuss the differences between the two different results of each test-taking (i.e., as him or herself and as a person from diverse culture). Focus on questions such as the following:
   a. Did being from a minority culture influence the results of the test?
   b. Did some tests have more biases than others?
   c. What would a culturally sensitive counselor need to do when administering,scoring, and interpreting these tests?

Exercise VI for Objective 7: Assessment for Multicultural Counselor Competency

1. Require the students to take the Multicultural Counseling Awareness Scale-Revised: Form B (MCAS) or the Multicultural Counseling Inventory (MCI).
2. Ask them to write a brief report regarding the results focusing on their level of cultural awareness of diverse populations with addictions. Ask them to include a possible rationale for their personal assessment, and a prescriptive plan for improvement of their cultural awareness.

Exercise VII for Objective 8: Cultural Concepts, Theories, and Treatment Approaches for People with Addictions

1. Divide the class into small groups. Have each group discuss the role of society in the treatment of people with addictions. Is society's role different or the same for people with addictions from diverse populations? Discuss these issues with the class.
2. Divide the students into small groups: Invite them to discuss the benefits and limitations of abstinence as a treatment goal for diverse populations with addictions. Ask them to brainstorm alternative treatment goals for this population followed with a classroom discussion.